AMENDED IN ASSEMBLY JUNE 19, 2008

AMENDED IN SENATE MAY 23, 2008

AMENDED IN SENATE APRIL 23, 2008

AMENDED IN SENATE APRIL 9, 2008

SENATE BILL No. 1553

Introduced by Senator Lowenthal
(Coauthor: Senator Kuehl)
(Coauthors: Assembly Members Berg, Hernandez, and Huffman)

February 22, 2008

An act to amend Sections 1363.5, 1367.01, ~~1367.26,~~ 1368, ~~1371, 1371.1,~~ 1371.4, ~~1373.95, 1374.16,~~ *1373.95,* and 1387 of, and to add Sections 1348.7 and 1363.3 to, the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 1553, as amended, Lowenthal. Health care service plans.

Existing law provides for licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law imposes various requirements on health care service plans, including, among other things, requirements related to authorization, modification, or denial of health care services to an enrollee and review of those decisions through grievance, departmental review, and independent medical review systems. A willful violation of provisions governing health care service plans is a crime.

This bill would require health care service plans offering professional mental health services or specialized plans offering those services to establish Web sites containing specified information, updated at least every month, and would require plans to issue a benefits card to

enrollees. The bill would modify provisions relating to disclosure by all health care service plans of the process used to authorize, modify, or deny health care services and would provide that decisions to deny requests by providers for authorization or to deny claim reimbursement shall not be based on whether admission was voluntary or involuntary or the method of transportation to the health care facility. The bill would ~~revise provisions governing authorizations for care, timeliness of payment of claims made for health care services, and overpayment of claims.~~ *require a plan employee to act as an ombudsperson to oversee the grievance process and would provide for a provider to file a grievance on an enrollee's behalf.* The bill would extend to specialized health care service plans that offer mental health care services certain requirements relating to authorization for medical care following stabilization of an emergency medical condition and to continuity of care policies that are now only applicable to full service plans. ~~The bill would extend to all specialized health care service plans requirements to establish and implement a procedure for a standing referral of an enrollee to a specialist.~~ The bill would revise provisions relating to imposition of civil penalties by the department by deleting the current $2,500 maximum amount of the civil penalty. The bill would enact other related provisions.

Because this bill would impose additional requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1348.7 is added to the Health and Safety Code, to read:

1348.7. (a) On or before January 1, 2010, every health care service plan that offers professional mental health services or a specialized health care service plan that offers those services and that is licensed to do business in the State of California shall

establish a plan Web site. The purpose of the plan Web site shall be to provide consumer, patient, and provider access to plan procedures, policies, and network provider information.

(b) Each plan Web site shall minimally include the drug formulary used by the plan, and the plan policies and procedures mandated by statute or regulation to be submitted to the department.

(c) The material required in subdivision (b) shall be updated at least every month.

(d) On or before January 1, 2010, the department shall establish minimum standards and guidelines for plan Web sites, after consultation with stakeholder groups, including, but not limited to, individual, group, and institutional providers and consumer protection groups. The minimum Web site standards developed by the department shall be implemented by each plan by January 1, 2011.

SEC. 2. Section 1363.3 is added to the Health and Safety Code, to read:

1363.3. (a) Every health care service plan that offers professional mental health services or a specialized health care service plan that offers those services shall issue a benefits card to each enrollee for mental health benefits coverage information, in-network provider access information, and claims processing purposes. The benefits card shall, at a minimum, include the following information:

(1) The name of the benefit administrator or health care service plan issuing the card, which shall be displayed on the front side of the card.

(2) The enrollee's identification number, or the subscriber's identification number when the enrollee is a dependent who accesses services using the subscriber's identification number, which shall be displayed on the front side of the card.

(3) A telephone number that enrollees may call 24 hours a day, seven days a week, for assistance about health benefits coverage information, in-network provider access information, and claims processing.

(4) A telephone number that providers may call for assistance.

(5) Information required by the benefit administrator or health care service plan that is necessary to commence processing a claim, except as provided in paragraph (5).

(6) A health care service plan shall not print any of the following information on a benefits card:

(A) Any information that may result in fraudulent use of the card.

(B) Any information that is otherwise prohibited by law or regulation from being included on the card.

(b) Beginning July 1, 2009, the benefits card required by subdivision (a) shall be issued by a health care service plan to an enrollee upon enrollment or upon any change in the enrollee's coverage that impacts the data content or format of the card.

(c) Nothing in this section requires a health care service plan to issue a separate card for prescription drug coverage if the plan issues a card for health care coverage in general and the card accommodates the information required by subdivision (a).

(d) For purposes of this section, if a health care service plan delegates responsibility for issuing the benefits card to a contractor or agent, the contract between the health care service plan and its contractor or agent shall require compliance with this section.

SEC. 3. Section 1363.5 of the Health and Safety Code is amended to read:

1363.5. (a) A plan shall disclose to the director and to network providers the process used to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities, whether the process is carried out by the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers, including, but not limited to, mental health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. The plan may make the criteria or guidelines available through electronic communication, upon request.

(c) The disclosure required by subdivision (a) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

~~SEC. 4. Section 1367.01 of the Health and Safety Code is amended to read:~~

~~1367.01. (a) (1) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.~~

~~(2) A plan may not deny claim reimbursement when a provider provides treatment in good faith based on the enrollee's inadvertent withholding of health coverage information.~~

~~(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the~~

process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify,

~~or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.~~

~~(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:~~

~~(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000. In cases where the information is necessary to make a determination, the plan shall notify the provider and enrollee of the omitted or outstanding documentation within three business days of receipt of insufficient information.~~

~~(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours of receipt of the documentation described in paragraph (7). Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable~~

~~to all health plans and other entities conducting utilization review or utilization management.~~

~~(3) Decisions to deny requests by providers for authorization or deny claim reimbursement shall not be based on (A) whether admission was voluntary or involuntary; or (B) the method of transportation to the health care facility.~~

~~(4) Decisions to approve, modify, or deny requests by providers for authorization prior to or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.~~

~~(5) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone, facsimile, or other electronic means within 24 hours of the decision, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the health care provider, subscriber, or enrollee to easily contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee or subscriber may file a~~

~~grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.~~

~~(6) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in this subdivision because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in this subdivision or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered.~~

~~(7) A request for approval shall be deemed complete upon receipt of the following documents: (A) chief complaint or complaints, including pertinent history and (B) diagnosis, where determined. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in this subdivision.~~

~~(8) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. Any penalty order issued by the director may also~~

include, but is not limited to, the remedies listed in Section 1374.28. These penalties shall be paid to the Managed Care Fund.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 5. Section 1367.26 of the Health and Safety Code is amended to read:

1367.26. (a) A health care service plan shall provide a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

(1) Primary care providers.

(2) Medical groups.

(3) Independent practice associations.

(4) Hospitals.

~~(5) All other available contracting physicians, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.~~

~~(b) The list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.~~

~~(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can use to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.~~

~~(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Web site. Plans shall ensure that the information provided is updated at least monthly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.~~

~~(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspecialty qualifications a specialist may have.~~

~~(f) The plan shall also provide a telephone number that enrollees, subscribers, and providers can contact to obtain information regarding a particular provider 24 hours per day and seven days per week.~~

~~(g) All information required in subdivisions (a) to (f), inclusive, shall be updated in writing annually as well as updated on the plan Web site every month. The plan shall send out annual contact information request forms to all providers within the plan network.~~

SEC. 4. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively,

retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's

request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the ~~decisionmaking~~ *decision making* process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees~~,~~ shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to deny requests by providers for authorization or deny claim reimbursement shall not be based on either of the following:

(A) Whether admission was voluntary or involuntary.

(B) The method of transportation to the health facility.

~~(3)~~

(4) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

~~(4)~~

(5) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the

provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

~~(5)~~

(6) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required.

The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

~~(6)~~

(7) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the ~~State~~ Managed Care Fund.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means

for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

~~SEC. 6.~~

SEC. 5. Section 1368 of the Health and Safety Code is amended to read:

1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(iv) The reference number assigned to each grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational

treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's member identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the plan representative who took the call and resolved the grievance.

(vii) The reference number assigned to each grievance.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(7) Assign a plan employee to act as an ombudsperson to oversee the grievance process as well as communications between the plan and the subscriber or enrollee.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process

for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Health Care Services, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a "relative" includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and

payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Fund.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the subscriber's or enrollee's grievance is sustained in whole or part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically

necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

(A) Order the plan to promptly offer and provide those health care services to the enrollee.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and

Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) As part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this section shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has, or filing a grievance on the enrollee's behalf after obtaining proper enrollee authorization, regarding compliance with or enforcement of this chapter.

~~SEC. 7. Section 1371 of the Health and Safety Code is amended to read:~~

~~1371. (a) A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but~~

~~no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant, including the provider, and enrollee or subscriber, shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.~~

~~(b) Upon receipt of a claim, the plan shall provide acknowledgment of receipt within three working days to the provider and to the enrollee or subscriber. The acknowledgment of receipt shall be provided via electronic means unless the provider and enrollee or subscriber opts out of the electronic method of transmittal and requests all acknowledgment of receipts to be transmitted in writing. All new claims shall be given a reference number, provided to the provider and enrollee or subscriber, for easy access to the status of the claim.~~

~~(c) If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.~~

~~(d) For the purposes of this section, other than subdivision (e), a claim, or portion thereof, is reasonably contested where the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and~~

~~assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.~~

~~(e) A claim submitted to a health care service plan that offers professional mental health services or a specialized health care service plan that offers those services, or portion thereof, is reasonably contested where the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information requested by the plan may include nothing other than the following: (1) chief complaint or complaints including pertinent history; (2) findings from consultations and referrals to other health care providers; (3) diagnosis, where determined; (4) treatment plan and regimen including medications prescribed; (5) progress of the treatment; (6) prognosis including significant continuing problems or conditions; (7) pertinent reports of diagnostic procedures and tests, and all discharge summaries; and (8) objective findings from the most recent examination.~~

~~(f) If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a plan has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 30 working days of the receipt of that information, or if the plan is a health maintenance organization, within 45 working days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.~~

~~(g) If the claim is denied for lack of medical necessity, then specific reasoning shall be included to explain why the service is not medically necessary.~~

~~(h) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical~~

~~groups, independent practice associations, or other contracting entities to pay claims for covered services.~~

~~SEC. 8. Section 1371.1 of the Health and Safety Code is amended to read:~~

~~1371.1. Whenever a health care service plan, including a specialized health care service plan, determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the health care service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the health care service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. If the overpayment is contested, no interest shall apply to the contested portion until the date of resolution of the contested reimbursement.~~

~~If the provider does not make reimbursement for an uncontested overpayment postmarked within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.~~

~~This section does not apply if the plan has mistakenly overpaid a claim based on plan oversight, error, or negligence. In those cases, no reimbursement for overpayment may be sought.~~

~~SEC. 9.~~

SEC. 6. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service plan, including a specialized health care service plan that offers professional mental health care services, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon and a licensed mental health practitioner shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for

payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j) (1) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 and that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, do all of the following:

(A) Discuss the enrollee's medical record with the noncontracting physician and surgeon or an appropriate representative of the hospital.

(B) Transmit any appropriate portion of the enrollee's medical record requested by the appropriate hospital representative or the noncontracting physician and surgeon to the hospital by facsimile transmission or electronic mail, whichever method is requested by the appropriate hospital representative or the noncontracting physician and surgeon. The health care service plan shall transmit the record in a manner that complies with all legal requirements to protect the enrollee's privacy.

(C) Either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 and that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) Paragraphs (1) and (2) do not apply to a physician and surgeon who provides medical services at the hospital.

(4) A health care service plan that meets the criteria set forth in paragraphs (3) and (4) of subdivision (a) of Section 1262.8 shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(5) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Health Services.

(6) For purposes of this section, "poststabilization care" means medically necessary care following stabilization of an emergency medical condition.

~~SEC. 10.~~

SEC. 7. Section 1373.95 of the Health and Safety Code is amended to read:

1373.95. (a) (1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.

(2) A health care service plan shall include all of the following in its written continuity of care policy:

(A) A description of the plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

(B) A description of the manner in which the plan facilitates the completion of covered services pursuant to the provisions of Section 1373.96.

(C) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services.

(D) A description of the plan's process to review an enrollee's request for the completion of covered services.

(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider.

(3) If approved by the department, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The plan shall file a revision of the policy with the department if it makes a material change to it.

(b) (1) The provisions of this subdivision apply to every health care service plan that offers professional mental health services or a specialized health care service plan that offers those services, ~~including~~ *including* a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(2) The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for a new enrollee who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account on a case-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect

a safe transfer. The policy shall ensure that reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition. The policy shall describe the plan's process to review an enrollee's request to continue his or her course of treatment with a nonparticipating mental health provider. Nothing in this paragraph shall be construed to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.

(3) A plan may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the plan determines that an enrollee's health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.

(4) The written policy shall not apply to an enrollee who is offered an out-of-network option or to an enrollee who had the option to continue with his or her previous specialized health care service plan that offers professional mental health services on an employer-sponsored group basis or mental health provider and instead voluntarily chose to change health plans.

(5) This subdivision shall not apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis if it includes out-of-network coverage that allows the enrollee to obtain services from his or her existing mental health provider or nonparticipating mental health provider.

(c) The health care service plan, including a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall provide to all new enrollees notice of its written continuity of care policy and

information regarding the process for an enrollee to request a review under the policy and shall provide, upon request, a copy of the written policy to an enrollee.

(d) Nothing in this section shall require a health care service plan or a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(e) The following definitions apply for the purposes of this section:

(1) "Hospital" means a general acute care hospital.

(2) "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed clinical social worker who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

~~SEC. 11. Section 1374.16 of the Health and Safety Code is amended to read:~~

~~1374.16. (a) Every health care service plan shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan shall require that the specialist provide the identified primary care physician with regular reports on the health care provided to the enrollee.~~

~~(b) Every health care service plan shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time~~

~~and is life-threatening, degenerative, chronic, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.~~

~~(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.~~

~~(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist available in a reasonable timeframe within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician as documented in the treatment plan developed pursuant to subdivision (a) or (b).~~

~~(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the~~

~~life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.~~

~~(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.~~

~~(g) This section shall become operative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier.~~

~~SEC. 12.~~

SEC. 8. Section 1387 of the Health and Safety Code is amended to read:

1387. (a) Any person who violates any provision of this chapter, or who violates any rule or order adopted or issued pursuant to this chapter, shall be liable for a civil penalty, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the director in any court of competent jurisdiction.

(b) As applied to the civil penalties for acts in violation of this chapter, the remedies provided by this section and by other sections of this chapter are not exclusive, and may be sought and employed in any combination to enforce this chapter.

(c) No action shall be maintained to enforce any liability created under subdivision (a), unless brought before the expiration of four years after the act or transaction constituting the violation.

~~SEC. 13.~~

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

CORRECTIONS:

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